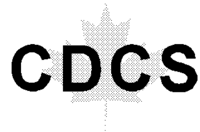

# CDCS HEALTH CLAIMS INC.

58 Lisgar St., Suite 300, , Sudbury, ON P3E 3L7 705-675-2222

P.O. Box 156 Stn. "B", Sudbury, ON P3E 4N5 800-265-2327

## BENEFIT CHANGE REPORT

| EMPLOYER INFORMATION | |
|---|---|
| EMPLOYERS NAME: | GROUP NUMBER: |

| TYPE OF CHANGE: | | | |
|---|---|---|---|
| 1. | NEW ENROLMENT – Attach completed enrolment form | 6. | SALARY CHANGE – Show new salary in explanation Section |
| 2. | TERMINATION – Indicate last day worked | 7. | BENEFICIARY CHANGE – Attach completed change of beneficiary form |
| 3. | REINSTATEMENT/REHIRE – Indicate previous termination date | 8. | TRANSFER – Indicate old and new division in explanation section |
| 4. | CLASS CHANGE – Show old and new class in explanation section | 9. | OTHER – Provide details in explanation section |
| 5. | DEPENDENT STATUS CHANGE – Show new status in explanation section. If adding new dependents attach completed insured dependent update form. | | |

### EMPLOYEE BENEFIT CHANGE INFORMATION

| EMPLOYEE LAST NAME, FIRST NAME | CERTIFICATE NUMBER | TYPE OF CHANGE | EFFECTIVE DATE (dd/mm/yyyy) | EXPLANATION |
|---|---|---|---|---|
| | | | | |
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### EMPLOYER AUTHORIZATION

| | | |
|---|---|---|
| NAME (Please Print) | SIGNATURE | DATE SIGNED (dd/mm/yyyy) |